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# **WPA Position Statement on Spirituality and Religion in Psychiatry**

WPA Section on Religion, Spirituality and Psychiatry

The World Psychiatric Association (WPA) and the World Health Organization (WHO) have worked hard to assure that comprehensive mental health promotion and care are scientifically based and, at the same time, compassionate and culturally sensitive<sup>1,2</sup>. In recent decades, there has been increasing public and academic awareness of the relevance of spirituality and religion to health issues. Systematic reviews of the academic literature have identified more than 3,000 empirical studies investigating the relationship between religion/spirituality (R/S) and health<sup>3,4</sup>.

In the field of mental disorders, it has been shown that R/S have significant implications for prevalence (especially depressive and substance use disorders), diagnosis (e.g., differentiation between spiritual experiences and mental disorders), treatment (e.g., help seeking behavior, compliance, mindfulness, complementary therapies), outcomes (e.g., recovering and suicide) and prevention, as well as for quality of life and wellbeing<sup>3,4</sup>. The WHO has now included R/S as a dimension of quality of life<sup>5</sup>. Although there is evidence to show that R/S are usually associated with better health outcomes, they may also cause harm (e.g., treatment refusal, intolerance, negative religious coping, etc.). Surveys have shown that R/S values, beliefs and practices remain relevant to most of the world population and that patients would like to have their R/S concerns addressed in healthcare<sup>6-8</sup>.

Psychiatrists need to take into account all factors impacting on mental health. Evidence shows that R/S should be included among these, irrespective of psychiatrists' spiritual, religious or philosophical orientation. However, few medical schools or specialist curricula provide any formal training for psychiatrists to learn about the evidence available, or how to properly address R/S in research and clinical practice<sup>7,9</sup>.

In order to fill this gap, the WPA and several national psychiatric associations (e.g., Brazil, India, South Africa, UK, and USA) have created sections on R/S. WPA has included "religion and spirituality" as a part of the "Core Training Curriculum for Psychiatry"<sup>10</sup>.

Both terms, religion and spirituality, lack a universally agreed definition. Definitions of spirituality usually refer to a dimension of human experience related to the transcendent, the sacred, or to ultimate reality. Spirituality is closely related to values, meaning and purpose in life. Spirituality may develop individually or in communities and traditions. Religion is often seen as the institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the sacred or divine, as held by a community or social group<sup>3,8</sup>.

Regardless of precise definitions, spirituality and religion are concerned with the core beliefs, values and experiences of human beings. A consideration of their relevance to the origins, understanding and treatment of psychiatric disorders and the patient's attitude toward illness should therefore be central to clinical and academic psychiatry. Spiritual and religious considerations also have important ethical implications for the clinical practice of psychiatry<sup>11</sup>. In particular, the WPA proposes that:

1. A tactful consideration of patients' religious beliefs and practices as well as their spirituality should routinely be considered and will sometimes be an essential component of psychiatric history taking.



2. An understanding of religion and spirituality and their relationship to the diagnosis, etiology and treatment of psychiatric disorders should be considered as essential components of both psychiatric training and continuing professional development.
3. There is a need for more research on both religion and spirituality in psychiatry, especially on their clinical applications. These studies should cover a wide diversity of cultural and geographical backgrounds.
4. The approach to religion and spirituality should be person-centered. Psychiatrists should not use their professional position for proselytizing for spiritual or secular worldviews. Psychiatrists should be expected always to respect and be sensitive to the spiritual/religious beliefs and practices of their patients, and of the families and carers of their patients.
5. Psychiatrists, whatever their personal beliefs, should be willing to work with leaders/members of faith communities, chaplains and pastoral workers, and others in the community, in support of the well-being of their patients, and should encourage their multi-disciplinary colleagues to do likewise.
6. Psychiatrists should demonstrate awareness, respect and sensitivity to the important part that spirituality and religion play for many staff and volunteers in forming a vocation to work in the field of mental health care.
7. Psychiatrists should be knowledgeable concerning the potential for both benefit and harm of religious, spiritual and secular worldviews and practices and be willing to share this information in a critical but impartial way with the wider community in support of the promotion of health and well-being.

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